ANDULAN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	<u> </u>	 -		RM APPRO	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
		TN1401	B. WING				
NAME OF PROVIDER OR SUPPLIES				09/28/2015			
CELINA H	EALTH AND REHAE	TO DITC	DUKESS, CITY OCK LANE	, STATE, ZIP CODE			
		CELINA	TN 38551	i			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES						
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS REFERENCE FOR THE PROPERTY OF THE PROPERTY		(X5) COMPLE	
NI DOA	1000		<u> </u>	CROSS-REPERENCED TO THE APPROI	RIATE	DATE	
N 031	1200-8-608 (1) Bu	ilding Standards	N 831				
(1) A nursing home :	shall construct, arrange, and	<u> </u> 	N831		-	
		ALL OF LOW Observation 1 and 1	ļ	1. The broken roof joist was		} !	
	the overall nursing home environment in such a manner that the safety and well-being of the residents are assured.			repaired by the Director			
, , ,				Maintenance on 10/9/15.	Я		
; ``	residerits are assured.			2. The remaining roof joists	Y2A	•	
į				inspected on 10/9/15 by t	vere he	Cometer	
;	j			Director of Maintenance	in.	Completi Date	
. Ti	his Rule is not met	20 Ovidan 41	J	ensure that there are no of	her		
, Hased oil noselvalia		is the feetile, the including		broken joists. No other ro	roof 10		
m.	aintain the overall e	nvironment.	ŀ	joists were found to be	01	i i	
i			j	affected.		1	
	e finding included:			3. The maintenance departme	nt		
Ot	servation on 9/28/5	2015 at 10:20 AM, revealed	J	was in serviced on 10/23/	15		
	: " " TOY OU IVAL DEIWERN MANAGES A		1	regarding the maintenance	of		
į 3 ir	attic.	wild ill byvall	1	the roof joists by the			
. Thi	S finding พลง บลซ์ย	ad hy-natal		Administrator.	į		
,		finding was Verified by maintenance director acknowledged by administrator during exit		 The maintenance director 	will		
conference on 9/28/1		, and grow during exit	1	examine the roof joists	i		
İ			1	weekly for four weeks and			
1				then monthly for two mont	hs		
:		1	j	or until 100% compliance	is		
		į		achieved and thereafter to			
				according to the facilities		····	
!				preventative maintenance	1		
:				plan. All results will be			
ŧ			1	reported monthly x3 month by the Maintenance Directo	S		
!]	to the Quality Assurance). DL		
!		}	-	Performance Improvement			
į		<u> </u>	1	committee comprised of the	, !		
•		ļ		Medical Director,	> ! :	ľ	
			ſ			,	
i Of Health Ca	os English				!		
RY DIRECT	re naciliges TOR'S OR PROVIDER/SH	PPLIER REPRESENTATIVE'S SIGNATUR					
laul B	Sare	THE TOUR CONTRACTOR SIGNATUR	RE	Administration	cxes) DATE	

if continuation sheet 1 of 1

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AND DIA	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	0/01			1 APPR
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION : 01 - MAIN BUILDING 01	(X3) DATE SURVE COMPLETED	
				AND EDICOMO (1)	1 00%	LC-6160
NAME OF	DEC 100	J TN1401	B. WING		001	20124-
	PROVIDER OR SUPPLIER	SIREELA	DDRESS, CITY, STATE, ZIP CODE		1 09/	28/201
CELINA	HEALTH AND REHAE	BILITATION CENTI 120 PITC	OCK LANE			
(X4) ID	SUMMARY STA	CELINA,	TN 38551			
PRÉFIX TAG	CEMORI DEFICATION	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION	RECTION	; Q
			i TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	COMP
N 831	1200-8-608 (1) Bu	Jildino Standarde	1 11004	Administrator, Di	rector of	<u> </u>
			N 831	Nursing, Staffing	010101	
[(1) A nursing home	shall construct, arrange, and		Coordinator, Mini	mum Dafa	!
,	THE COUGHT	on of the physical plant and nome environment in such a	İ	Set Coordinator, S	ocial	<u>;</u>
	manifer manue san	BIV 200 Well-boing of the		Scrvices, Activitie	s Director.	
!	residents are assure	ed		Dietary Manager.	and	
į			[Housekeeping Sup	crvisor.	
្ត រុំ ត		Ì			ļ	
	Phie Bula iss					
	This Rule is not met Based on observatio	as evidenced by: ns, the facility failed to	1		ļ	
	naintain the overall	environment.				
	he finding included:		1			
C	Observation on 9/28/	2015 at 10:20 AM, revealed	1			
T a	broken roof joist be in attic.	tween firewall 2 and firewall				
	his finding was verifi nd acknowledged by onference on 9/28/1	ied by maintenance director y administrator during exit 5.				
; }						
!						
į					į	
į				•	•	
!			}	•	!	
!		}	1		ļ	
•			1		ļ	
į					į	
of Health	Care Facilities		<u>_</u>	<u></u>	:	
ATORY DIRE	ECTOR'S OR PROVIDER/S	UPPLIER REPRESENTATIVE'S SIGNATU	- <u></u>			
//		THOROTO CHARACTE	/1 <u>1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 </u>	TITLE		